Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

BOARD OF NURSING

INFORMATION FOR COMPLETING CERTIFICATION OF ADVANCED PRACTICE NURSE PRESCRIBERS APPLICATION

REQUIREMENTS:

An applicant for initial certification to issue prescription orders shall be granted a certificate by the board if the applicant complies with all of the following:

a) Has a current active license to practice as a professional nurse in this state.
b) Is currently certified by a national certifying body approved by the board as a nurse practitioner, certified nurse-mid-wife, certified registered nurse anesthetist or clinical nurse specialist.
c) For applicants who receive national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist after July 1, 1998, holds a master's degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the state board of education in the state in which the college or university is located.
d) Has completed at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application for a certificate to issue prescription orders.
e) Has passed a jurisprudence examination for advanced practice nurse prescribers.

INSTRUCTIONS FOR COMPLETING THE APPLICATION:

1. **Application (Form #2124):** Complete the enclosed application and attach the appropriate fee. Make check payable to "Department of Regulation & Licensing" and mail to the Board of Nursing at PO Box 8935, Madison WI 53708-8935. *See page 2 of this application for other required documents.*
2. **Certification of Master's Degree (Form #2367):** Complete and forward to the college or university at which you received your master's degree. This form must be returned directly to the Board of Nursing at PO Box 8935, Madison WI 53708-8935. Forms received from the applicant will be rejected by the board. If the school you graduated from is closed, contact the Department of Public Instruction in the state where you graduated to determine where the records for the closed school were transferred.
3. **Verification of your current national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist:** Contact your national certifying body to request a verification be sent directly to the Board of Nursing, P.O. Box 8935, Madison, WI 53708-8935.
4. **Jurisprudence Examination:** All candidates are required to successfully complete an open-book examination on Wisconsin Statutes and Rules relating to the practice of advanced practice nurse prescribers. Enclosed is a numbered examination booklet along with an answer sheet. You must return the entire examination booklet and answer sheet to the board office. The "Wisconsin Statutes and Administrative Code Relating to the Practice of Nursing" book is yours to keep.
5. **Malpractice Insurance Coverage:**
   Advanced practice nurse prescribers who prescribe independently shall maintain in effect malpractice insurance evidenced by one of the following:
   a) **Personal Liability Coverage:** Submit a copy of your certificate of insurance showing the limits of personal liability coverage in the amounts of ($1,000,000/$3,000,000) including dates of coverage.

   Coverage under a group liability policy providing individual coverage for the nurse in the amounts of ($1,000,000/$3,000,000):
   a) **Certificate of Insurance:** Submit a copy of your certificate of insurance showing the limits of personal liability coverage in the amounts of ($1,000,000/$3,000,000) including dates of coverage.

b) **Certification form for advanced practice nurse prescribers who do not carry personal liability insurance coverage (Form #2157)**. Complete this form to correspond with the type of coverage provided under the group policy. Please review the enclosed "Advanced Practice Nurse Prescriber Application Information" (Form # 2151) to determine your coverage.

c) **Current Employment Verification:** Request your employer to submit a letter verifying your current employment status directly to the Board of Nursing, PO Box 8935, Madison WI 53708-8935.

Every advanced practice nurse prescriber who is certified to issue prescription orders shall annually submit to the board by October 1st of each year satisfactory evidence that he or she has in effect malpractice insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 for all occurrences in one year.

GENERAL INFORMATION:

Biennial renewal: Renewal of certificates are before October 1st of even-numbered years as required by law if engaged in the practice as an advanced practice nurse prescriber. Renewal applications will be mailed 6-8 weeks prior to the renewal date and are to be returned with the renewal fee as specified in sec. 440.08(2), Stats. It will be necessary for the individual who is certified prior to October 1 of the biennial renewal period to renew if engaged in practice as an advanced practice nurse prescriber. Fees for renewing certificates are not prorated.

You must renew your license to practice as a professional nurse in order to hold a valid certificate to practice as an advanced nurse prescriber. Renewal of the advanced practice nurse prescriber certificate is conducted as a separate procedure from the renewal of the professional nurse license.

Continuing Education: Advanced practice nurse prescribers must document completion of an average of at least 8 contact hours per year in clinical pharmacology/therapeutics relevant to the area of practice. Evidence of completion of required continuing education shall be submitted to the Board on a schedule consistent with the schedule for submission of continuing education hours established by the national certifying body. You are required to maintain evidence of completion of continuing education for a minimum of 5 years.

No person may practice or attempt to practice as an advanced practice nurse prescriber or use the title advanced practice nurse prescriber or append to his or her name the letters' A.P.N.P. or otherwise indicate that he or she is certified to practice as an advanced practice nurse prescriber unless he or she is currently certified under sec. 441.16(2), Stats.

DEA REGISTRATION INFORMATION: The U.S. Drug Enforcement Administration (DEA) has authorized the issuance of mid-level practitioner registration numbers to APNP's.

Certified advanced practice nurse prescribers who anticipate that their practice will include preparing prescription orders for controlled substances will be required to register with the DEA on forms provided by that agency. Forms may be ordered from U.S. Drug Enforcement Administration, 230 S. Dearborn St. #1200, Chicago IL 60604, 1-800-882-9539 toll free 24 hrs. a day.

MAILING INSTRUCTIONS:

Mail the application, the appropriate fee, and supporting documentation to the following address:

DEPARTMENT OF REGULATION & LICENSING
BOARD OF NURSING
PO BOX 8935
MADISON WI 53708-8935

Wisconsin Department of Regulation & Licensing

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BOARD OF NURSING

APPLICATION FOR CERTIFICATION AS AN ADVANCED PRACTICE NURSE PRESCRIBER

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

Nursing School: _____

School Address: _____
(City) (State)

Date of Diploma: _____
month/day/year

Degree: _____

What is your state of primary residence?

_____

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?
☐ Yes ☐ No

APPLICATION FEES Please check applicable blank(s): (Make check payable to Department of Regulation and Licensing and attach to application.)

_____ $ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$110.00 Total fee attached

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application (Form #2124).

Certification of masters degree (Form #2367)

Verification of current national certification

Wisconsin Statutes and Rules Examination Booklet with answer sheet.

Evidence of malpractice insurance coverage.

Letters from all state boards where credentialed (includes active and inactive credentials) as an advanced practice nurse prescriber.

Copies of malpractice suit(s). Court documents with allegations and settlement (if applicable).

Social Security Form (page 6 of 6 Form 2124)

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

I AM CURRENTLY CERTIFIED AS: (check one)

- ❑ Nurse Practitioner - Specialty: _____
- ❑ Clinical Nurse Specialist - Specialty: _____
- ❑ Certified Registered Nurse Anesthetist
- ❑ Certified Nurse-Midwife

I HOLD CURRENT CERTIFICATION BY: (Check all that apply & submit proof)

❑ American Academy of Nurse Practitioners	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ American Assoc. of Nurse Anesthetists	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ American College of Nurse-Midwives	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ ANA Credentialing Center	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ Nat'l Certification Board of Pediatric Nurse Practitioners & Nurses	Cert. No.	_____	Grant Date	_____	Exp. Date	_____
❑ Nat'l Certification Corporation for OB, GYN & Neonatal Nursing Specialties	Cert No.	_____	Grant Date	_____	Exp. Date	_____
❑ Am. Assn. of Critical Care Nurses Cert. Corp., (949) 362-2050, Clinical Nurse Specialist (Acute and Critical Care)	Cert No.	_____	Grant Date	_____	Exp. Date	_____

"Clinical pharmacology/therapeutics," as defined in sec. N 8.02(4), Wis. Admin. Code, means the identification of individual and classes of drugs, their indications and contraindications, their likelihood of success, their side-effects and their interactions, as well as, clinical judgment skills and decision-making, based on thorough interviewing, history-taking, physical assessment, test selection and interpretation, pathophysiology, epidemiology, diagnostic reasoning, differentiation of conditions, treatment decisions, case evaluation and non-pharmacologic interventions.

I HAVE COMPLETED AT LEAST 45 CONTACT HOURS IN CLINICAL PHARMACOLOGY/THERAPEUTICS WITHIN 3 YEARS PRECEDING THIS APPLICATION. (Contact hours for academic courses are assigned as follows: 1 semester credit = 15 contact hours; 1 quarter credit = 10 contact hours; 1 CEU = 10 contact hours)

❑ YES ❑ NO ATTACH PHOTOCOPIES FOR CERTIFICATES OF COMPLETION OR TRANSCRIPTS OF COURSES ATTENDED WITHIN THE LAST 3 YEARS INCLUDING THE DATE WHICH THE COURSES WERE TAKEN.

I AM CREDENTIALED IN THE FOLLOWING STATES (UNLIMITED) AS AN ADVANCED PRACTICE NURSE PRESCRIBER:

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN BOARD OF NURSING. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Do you hold a current Wisconsin License as a Registered Nurse? License # _____ Expiration Date _____	☐	☐
2.	Do you have current **personal** liability malpractice insurance coverage? If yes, submit a copy of your certificate of insurance showing the limits of personal liability coverage, including dates of coverage.	☐	☐
3.	Do you have current **group** malpractice liability insurance coverage? If yes, submit a copy of your certificate of insurance showing the limits of personal liability coverage, including dates of coverage and complete the certification form #2157 enclosed.	☐	☐
4.	Have you ever had a finding of abuse or misappropriation placed against you on the Wisconsin Nurse Aide Registry of the Department of Health & Social Services or any other state's registry? If yes, give details on an attached sheet, including date and type of action.	☐	☐
5.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	☐	☐
6	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
7.	Have you ever failed to pass any state board examination, providence of Canada examination, or NCLEX examination? If yes, give details on an attached sheet.	☐	☐
8.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
9.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
10.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
11.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
12.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	☐	☐
13.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
14.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	☐	☐
15.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐
16.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	☐	☐

Wisconsin Department of Regulation & Licensing

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as an advanced practice nurse prescriber" is to be construed to include all of the following:

1. The cognitive capacity to exercise reasoned advanced practice nurse prescriber judgments and to learn and keep abreast of advanced practice nurse prescriber developments; and
2. The ability to communicate those judgments and advanced practice nurse prescriber information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform advanced practice nurse prescriber tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
17.	Do you have a medical condition which in any way impairs or limits your ability to practice as an advanced practice nurse prescriber with reasonable skill and safety? If yes, please explain.	❑	❑
18.	Does your use of chemical substance(s) in any way impair or limit your ability to practice as an advanced practice nurse prescriber with reasonable skill and safety? If yes, please explain.	❑	❑
19.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	❑	❑
20.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	❑	❑
21.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	❑	❑
22.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
23.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

AFFIDAVIT *OF APPLICANT*
(Sign and date <u>in the presence of</u> a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Board of Nursing or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of_____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

SEAL

_____
Date Commission Expires

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name **Middle Initial** **Last Name**

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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BOARD OF NURSING

CERTIFICATION OF MASTER'S DEGREE

APPLICANT: Complete the top of this page and forward it to the college or university at which you received your master's degree. Request the college/university to return the completed form directly to the **Wisconsin Board of Nursing**.

Information requested is required for processing.

*SS# _____
(optional)

NAME: _____
(last) (first) (middle) (other/previous)

ADDRESS: _____
(street) (city) (state) (zip)

MASTER'S DEGREE PROGRAM COMPLETED AT: _____
(name of college/university)

LOCATION: _____ DATE OF COMPLETION: _____
(city) (state)

I hereby authorize the _____ college/university to furnish the WISCONSIN BOARD OF NURSING the information requested below.

DATE: _____ SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE - FOR COLLEGE/UNIVERSITY

This is to certify that _____
(name)

successfully completed the master's program at _____
(name of college/university)

_____ and completed on _____
(location)

Was the master's degree in nursing? YES_____ NO _____

If no, please provide the title of the degree granted: _____

Was this college/university regionally accredited at the time of graduation? YES _____ NO_____

SCHOOL SEAL/STAMP

Signed: _____

*Voluntary, for use in school locating your records.

Title: _____

Date: _____

#2367 (6/03)
Ch. 441, Stats.

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BUREAU OF HEALTH SERVICE PROFESSIONS

ADVANCED PRACTICE NURSE PRESCRIBER
APPLICATION INFORMATION

IMPORTANT -- PLEASE READ

Section N 8.08 of the board's Administrative Code provides that advanced practice nurse prescribers "shall maintain in effect malpractice insurance in an amount not less than the amount set forth in s. 655.23(4), Stats." With three exceptions, the rule requires that the applicant have **individual professional liability coverage of $1,000,000 for each occurrence and $3,000,000 for all occurrences in any one policy year**.

The exceptions to the requirement for individual coverage are as follows:

(1) Where the advanced practice nurse prescriber practices as the employee of the state or of a governmental subdivision.

(2) Where the advanced practice nurse prescriber is covered under a group liability policy providing individual coverage for the nurse in the amounts set forth in sec. 655.23(4), Stats.

(3) Where the advanced practice nurse prescriber works under the direction and supervision of a physician or nurse anesthetist, and does not prescribe independently.

Applicants for certification as advanced practice nurse prescribers who have group malpractice coverage rather than an individual professional liability policy, must determine whether the policy provides individual coverage or only shared coverage. If the policy provides only for shared coverage, and if the applicant intends to prescribe independently, the policy does not meet the requirements of section N 8.08, Code, and it will be necessary for your group practice to change your coverage to individual coverage in the amounts specified, either through amendment to the group policy or by acquiring individual personal liability coverage in the amounts specified. If the certificate of insurance or insurance declaration submitted as proof of insurance does not establish whether coverage is individual or shared, a supplementary declaration from the insurer or a certification of individual coverage from the insurer or your employer must be provided.

If you do not have an individual professional liability policy, it will be necessary for you to complete the appropriate section(s) of the certification form included with your application materials. THE RISK MANAGER OR OTHER PERSON ADMINISTERING YOUR FACILITY'S INSURANCE PROGRAM SHOULD BE ABLE TO ASSIST YOU IN DETERMINING THE CORRECT SECTION TO COMPLETE.

Wisconsin Department of Regulation & Licensing

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BOARD OF NURSING

CERTIFICATION FORM FOR ADVANCED PRACTICE NURSE PRESCRIBERS
WHO DO NOT CARRY PERSONAL LIABILITY INSURANCE COVERAGE

(Complete all that apply)

I am an advanced practice prescriber who practices as the employee of a health care provider and I am covered by a group liability policy providing individual coverage in the amounts set forth in sec. 655.23(4), Stats. I certify that I will prescribe only within the limits of the policy's coverage, or shall obtain personal liability coverage for independent prescribing outside the scope of the group liability policy or policies.

NAME _____ _____ _____
PLEASE PRINT Signature Date

I am an advanced practice prescriber who practices as the employee of a health care provider and I am covered by a group liability policy providing shared coverage. I certify that I will prescribe only under supervision of and as delegated by a physician or certified registered nurse anesthetist and consistent with the requirements for delegated acts established by secs. N 6.03(2) and (3), Code, or shall obtain personal liability coverage for independent prescribing outside of my employment setting.

NAME _____ _____ _____
PLEASE PRINT Signature Date

I am an advanced practice prescriber who practices as the employee of this state or a governmental subdivision, as defined under sec. 180.0103, Stats. I certify that I will prescribe only within the established scope of my employment, or shall obtain personal liability coverage for independent prescribing outside of my government employment setting.

NAME _____ _____ _____
PLEASE PRINT Signature Date

#2157 (Rev. 6/03)
Ch. 441, Stats.

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Social Security Number
month _____ day _____ year _____	Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

		YES	NO	MO/YR COMPLETED
3.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
	Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

	(Check all that apply)	YES	NO	MO/YR COMPLETED
4. Have you ever been sentenced to:	☐ Probation	☐	☐	_____
	☐ Parole	☐	☐	_____
	☐ Ordered to pay restitution	☐	☐	_____
Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____ _____

Signature Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

Department of Regulation & Licensing

State of Wisconsin
(608) 266-2112
TTY# (608) 267-2416] hearing or speech
TRS# 1-800-947-3529] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 267-1803

NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 10/00) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code

Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: **(608) 261-7083**
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

APPLICATION PACKET ADDENDUM (INTERNET)

ADVANCED PRACTICE NURSE

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

_____ _____
Full Name Daytime Phone Number

_____
Street Address

_____
PO Box

_____
City, State, Zip

Thank you.

#2612 (4/03)